Special care
for chronic heart failure patients

When David Rabe, 60, started experiencing shortness of breath at night – he thought it would eventually go away. But the problem persisted until he mentioned it to his wife during a car ride home one weekend after visiting family.

"When we got home I called the My Nurse line," said Linda Rabe, David's wife. "The nurse recommended we go to the Emergency Room right away. Within two minutes of arriving at St. Luke's ER we saw a doctor who diagnosed him."

"He said my heart was in atrial fibrillation (A-Fib), which means the upper part of my heart was beating faster than the rest of my heart," said David Rabe. "The ER doctor admitted me to the hospital."

His fast heart rate had caused his heart to weaken. Besides a diagnosis of A-Fib, David was also diagnosed with chronic heart failure. This is when an individual has fluid on their lungs. In most patients, the fluid gets there because the heart is weak and it backs up in the lungs. In a smaller group of patients chronic heart failure is related to a heart muscle that has normal function but is stiff.

In David's case medication was prescribed to control his heart problems. He also participated in a St. Luke's program that teaches chronic heart failure patients about the benefits of a healthy diet and exercise.

Creating the ideal transition home

St. Luke's started the Transitions Home program in 2006, after learning more about the Institute for Healthcare Improvement's (IHI) Transforming Care at the Bedside program. IHI's national program aims to create an ideal transition home for patients who were being discharged from medical and surgical units.

"St. Luke's focused on heart failure because of the high readmission rate," said Peg Bradke, RN, MA, St. Luke's Heart Care Services director. "We looked at how we could make the patient's transition home more family friendly. And in particular, we identified specific ways where there was a breakdown in communication, which in many cases led to a patient being readmitted."

St. Luke's Heart Care Services set a goal of reducing unplanned heart failure (HF) readmissions by 50 percent. The team used a methodology, which included the patient and caregiver – ensuring that they fully understand their diagnosis, plan of care and follow-up care with their doctor. Sue Halter, ARNP, works closely with hospital staff, doctors, patients and their families to achieve the best possible outcome for heart failure patients.

To make these changes St. Luke's identified interventions to provide HF patients with the best transition either to home or a long-term care facility. Each discharged HF patient receives patient-friendly written information, a home visit from a nurse within 48 hours, a follow-up appointment with their doctor within three-to-five days and seven days after discharge the patient receives a follow-up telephone call from an advanced practice nurse. In addition, St. Luke's provides a calendar of useful patient information, a class on heart failure management and a refrigerator magnet listing the signs of heart failure.

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> Todd Noreuil, MD, Cardiologists, P.C.
> St. Luke's Chronic Heart Failure Program medical director.

"The whole idea behind the Transitions Home program is to get the patient engaged and involved in their healthcare," said Todd Noreuil, MD, Cardiologists, P.C., and St. Luke's Chronic Heart Failure Program medical director. "We do this by supporting them, learning about their condition and teaching them what they need to keep an eye on. All of the follow-up phone calls and visits are meant to reinforce the key points they learned during their hospital stay. These include taking their medications, the importance of salt restriction, checking weight gain and reporting any of these symptoms. Patients seem to really like it."

Signs of Heart Failure

If you have one or more of these symptoms:

- Weight gain of 3 pounds in 1 day *or*
- Weight gain of 5 pounds *or* more in 1 week
- More shortness of breath
- More swelling of your feet, ankles, legs or stomach
- Feeling more tired – no energy
- Dry, hacking cough
- Harder to breathe when lying down
- Chest pain

Call doctor ________________

at ________________

St. Luke's sends this refrigerator magnet home with heart failure patients.

"The nurses and hospital staff at St. Luke's really work with you – making sure you know the signs and symptoms," said Linda. "We were told David really needed to listen to his body. The information they provide is fantastic and is really in the best interest of the patient."

Success stories

"St. Luke's is having success with this program," said Dr. Noreuil. "The readmission rate for the last two-and-a-half years is at six percent. Nationally the 30-day readmission rate is 18 percent. The St. Luke's Transitions Home program has been recognized as an example for the rest of the nation in articles published in the "Wall Street Journal" and "Washington Post."

"I feel confident in what I need to do to maintain a healthy lifestyle and control my disease," said David. "We also plan to attend a class at St. Luke's that will provide us with additional information on living with chronic heart failure."

"I've been to several hospitals over the years but I have never been to one as good as St. Luke's," said Linda. "Everyone there from the doctors and nurses to the housekeepers and food service workers – they were all excellent – we wouldn't go anywhere else."

Learn if you're at risk for heart disease by taking the HEARTaware health risk assessment, go to stlukesheartaware.com.

David Rabe and his wife Linda play cards at their Cedar Rapids home.